DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Disability and Elder Services
DDE-818 (Rev. 12/2003)

STATE OF WISCONSIN
Completion of this form is mandatory
per s. 49.77, Wis. Stats.

CERTIFICATION FOR SSI-E EXCEPTIONAL EXPENSE SUPPLEMENT

Personally identifiable information collected on this form is confidential and will be used only to determine eligibility for services and for identification purposes.

1. To: State of Wisconsin
Department of Health and Family Services
P. O. Box 6680
Madison, WI 53716-0680

2. Type
☐ Natural Residential (NR) ☐ NR - SC
☐ Substitute Care (SC) ☐ SC - NR

3. Action
☐ Start
☐ Stop (decertification-answer question 12)

4. SSI-E Effective Date
_____/_____/_____
mo. day full year

5. Name - Applicant (Last, First, MI)

6. Social Security Number

7. Date of Birth
____/____/_____
mo. day full year

8. Telephone Number

9. Applicant Address

10. County of Residence

11. Age/Disability Group
☐ Elderly (65+)
☐ Physically disabled
☐ Alzheimer's/other dementia
☐ Developmental disabilities
☐ Mental Health
☐ AODA

12. If **STOP**, Decertification Reason
☐ Institutionalized more than 90 days
☐ Living arrangement no longer qualifies
☐ No longer receives/needs qualifying amount/type of services
☐ No longer severely disabled according to SSA
☐ Death
☐ Moved out of state
☐ Financially ineligible according to SSA
☐ Changed county of responsibility
☐ Other

I CERTIFY, this information is correct and the action is in accordance with sec. 49.77, Wis. Stats.
Re: Federal regulations 20 CFR 416

13. Name - Worker

14. Date Form Completed

15. Worker Telephone Number

16. **SIGNATURE** - Agency Director or Designee

17. Name - Representative Payee (if any)

18. Agency Name and Address

19. Representative Payee Address

20. Date Approved

21. Living Arrangement Upon Certification
☐ Foster Home for Children
☐ Group Home for Children
☐ Licensed or Certified Adult Family Home
☐ CBRF (8 beds or less)
☐ CBRF (9-20 beds)
☐ Grandfathered CBRF 20 or more beds (Name)
☐ Person's Own Home or Apartment
☐ Home/Apartment of Another
☐ Other (Specify)

I understand that signing this form means I am applying for the SSI-E Exceptional Expense Supplement.

SIGNATURE - Applicant/Representative

Application Date

If Representative, Relationship to Applicant

White and Green Copies: State of Wisconsin
DHFS
P. O. Box 6680
Madison, WI 53716-0680

Blue Copy: Applicant

Pink Copy: Agency Case Record

ACTION TAKEN

SSI-E CERTIFICATION

☐ I have processed this certification.

☐ I have not processed this certification.

(Reason(s)

SIGNATURE - State SSI Unit Worker	Date Signed